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Editorial

"STILL THE CINDERELLA?"

Psychiatric services have in the past been described as "the Cinderella of the medical services", but when the National Health Service came in, the idea arose that Cinderella had found her Prince at last, and that she would be getting at least as fair a deal as medicine and surgery (though the terms "the two Ugly Sisters" were not, of course, used!). This, it was hoped, would make up for the neglect of the past. We have since then heard about the increase of staff, new buildings, more out-patient clinics and the "mental million" (pounds, not patients). What are the facts?

From the Ministry of Health's Hospital Costing Returns for the Regional Board Hospitals for 1958/59, it is seen that the net average in-patient cost of mental hospitals per week has risen from £5 17s. 8d. in 1957 to £6 19s. 2d. in 1959. Considering rising prices, this does not sound much and it is in fact only a slightly higher rate of increase than the rise in the cost of chronic patients, which is from £8 13s. 5d. in 1957 to £10 4s. 0d. But the rate of "acute" hospitals rose from £19 11s. 1d. to £23 16s. 11d. (the term "acute" does not cover acute cases in mental hospitals). The breakdown shows clearly what is the prime cause of this difference —the cost of medical staff. The figures for the weekly cost of these in the various regions are also given. It is thus possible to compare the amount spent in the different types of hospital, and the comparison is rather shocking. It is true that it is not an entirely fair one, for many of the "acute" hospitals may be too small to be economic units. Nonetheless, the difference is too great to be explained away: the weekly figures for "acute" beds range from £1 18s. 11d. (Leeds) to £3 10s. 0d. (Manchester)—(a difference which itself must call for some explanation?)—while the costs for mental hospital beds range from 3s. 6d. (Manchester) to 7s. 3d. (Oxford). Mental deficiency beds, it must be noted, are shown separately and range from 1s. 7d. (East Anglia) to 5s. 8d. (Wessex and South West Metropolitan), and this, incidentally, demonstrates the remarkable fact that the two latter Boards are spending more on mental deficiency hospitals than five Regional Boards are spending on mental hospitals.

Thus we have the position that the least expensive "acute" hospital costs over five times as much as the most expensive mental hospital; or—to put it another way and a worse one—that the most expensive "acute" hospital spends twenty times more than the least expensive mental. It may be held, of course, that there are costs in "acute" hospitals (such as theatre costs) which have no counter-part in mental hospitals. We cannot tell how much this affects the situation, though there are theatres in mental hospitals too.

The stark fact is that treatment is often "too little and too late" : and it is well known to all who work in mental hospitals that the lack of staff still prevents adequate treatment being given to many patients, even though this treatment, e.g. simple psychotherapy, would make all the difference to their future. This cannot be concealed by any talk about the recent improvements made in mental hospitals or the "New Look" for mental health. The figures show only too clearly that mental hospitals are nowhere near parity with other specialities. It is true, of course, that consultants have increased (we are told, from 405 in 1949 to 648 in 1959), and that at senior registrar level, psychiatrists now form one-fifth of the national strength; and that clinical psychologists and psychiatric social workers have also considerably increased. This is certainly something, but it has hardly done more than keep pace with the expansion of out-patient clinics. So far as patients in hospital go, we cannot pretend there is any adequate standard of treatment throughout the country. To take an example of progress, one excellent provincial hospital has increased its total medical staff from 7 to 14 since 1948 and thus provides far better out-patient and domiciliary services, but many in-patients must still have far less attention than they require, for the amount of time a doctor can give to each individual can be seen by the roughest calculation to be far too small : there are 1,500 or so of them. The conclusion seems inescapable that gross neglect still goes on and that many patients are becoming chronic for lack of treatment, even though such treatment exists. The inevitable waste of health, happiness and of expense is still tragic. This will be so while there remains a gross shortage of medical staff. It may get worse as the present staff work themselves to exhaustion and psychosomatic disease.

How can we do better? It is not simply a question of money, though this is needed; it is a question, first, of training more psychiatrists, and secondly, of getting other, less skilled, professions, to take what they can on to their shoulders. Under the first head, the staff shortage is clearly most marked in the junior ranks, who have by no means increased so fast as the senior, if at all; so that in some places the staff structure is very top-heavy. There is something of a deadlock here, for vacancies are not advertised when it is thought no staff are available, and, on the other hand, doctors will not train to become psychiatrists if no openings seem to exist. Only a firm statement of policy and plans for the future will alter this situation, and perhaps the moment is opportune for this, at a time when some other specialities are decreasing. Both the Ministry of Health and the Regional Hospital Boards can surely show a lead here.

One can't help wondering why this hasn't been done before. There is, of course, the Englishman's preference for "muddling through" rather than planning ahead. There is another probable

resistance which ought to be discussed: many, very admirable citizens are afraid of recognising in public the expanding claims of psychiatry, and fear that "the sky's the limit". The more psychiatrists there are, they feel, the more patients will they find: and each of these will demand more psychiatric time. This fear has, alas, been encouraged by occasional psychiatric empire-building in the past. But it should not be difficult to provide a safeguard, and indeed it is easier to do so in a comprehensive plan than by allowing haphazard expansion. This safeguard is to put the emphasis of the enlarged service on prevention and on early treatment: as has already been done in certain notable experiments, such as at Worthing.

Under the second head, that is, the delegation of work to less trained people, progress is also being made; it also needs to go faster. There are many people in the community who are faced with psychiatric patients "willy nilly" and who have all too little training to help them deal with them. In this issue we are publishing an account of the needs of various professions, and how attempts are being made to meet them: general practitioners, nurses, social workers, and probation officers. (We may recall that in a previous issue we discussed the part the clergy can play.) It is evident that, here again, there is a big lag between the demand for training and its supply.

It may be true that there is not enough money and that there are not enough people interested in the subject. If so, we shall have to face the fact, but let us at least know about it, and let us not pretend that we have an adequate mental illness service as long as these gaps exist.

METHODS OF LEARNING

Elsewhere in this number, much has been said about the professions which are called on to deal with questions of mental health and mental illness, and the material they need to learn. Little has been said about the manner in which they best can learn: and it is most unlikely that even the little that is now provided is given in the most effective way. A "straight" lecture *may* still be the best way of imparting facts: though this is open to doubt: it is certainly not the best means of changing attitudes—which in this field is often very necessary.

It is therefore very interesting to be able to read in detail of the Aloka experience.* This project, carried out first in Ceylon and now transferred to Mysore, was designed to teach its members a greater awareness of their own needs and their own relationships. The difficulties are described which they experienced in dealing with their preconceptions—of how best to learn, and how the

* *The Tide of Learning: The Aloka Experience.* R. P. Lynton. Routledge & Kegan Paul. 230 pp. 25s.

faculty staff should behave, and particular attention is paid to their defences against accepting responsibilities. They had especial resistances against forming relationships "on their level", having been used largely to "up and down" relationships with superiors and subordinates.

These problems vary and are acute in rapidly developing nations, with intense pressure on emerging leaders, who thus are likely to be overloaded very quickly. In this sense, Aloka is well situated to deal with progress in South East Asia. But the problems which the Asian countries face in the field of material progress are not so dissimilar from those faced by countries whose history of material progress is longer, but who are now trying to cope with other responsibilities—and less tangible ones, like the mental health of the community. Here again, there will be insecurity and an attempt to seek refuge in old systems—instead of experimenting with new: new skills will need to be developed—new attitudes formed: and the people who can do so successfully will even then be regarded with some suspicion by others who cannot.

Any training courses which are organised in the various aspects of mental illness will need to have facilities for learning skills, and for strengthening their numbers in their ability to handle these problems. Simply to provide information could do more harm than good, and set the clock back.

Training in Child Guidance

By T. A. RATCLIFFE, M.A., M.B., D.P.M., D.C.H.

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In a recent article in *Mental Health* the present writer described some of the problems which arose from the sudden and great expansion of the Child Guidance Services in this country in the immediate post-World War II years.

One of these difficulties has been the grave shortage of adequately trained Child Guidance Clinic team members. No detailed, or accurate, figures appear to be available for the country as a whole, or as between the various disciplines concerned. Certainly conditions vary in different areas; and in general the southern portion of England is probably the more generously provided with trained personnel. But, taking the country as a whole, it seems doubtful if more than one in four of the Child Psychiatrists (of "consultant", or equivalent, status) have had *adequate* basic training in their particular section of the speciality of psychiatry. A considerably larger proportion of Educational Psychologists in Child Guidance Clinics appear to have had the generally accepted pattern of basic training and experience, although here, too, the training of some members of this discipline has been predominantly

in other sectors of the very wide professional field of psychology. Of the Psychiatric Social Workers, it could be argued justifiably that Child Guidance experience is an integral part of the training for the Certificate in Psychiatric Social Work; but it must be remembered that an appreciable number of clinic teams include general social workers, most of whom will not have had this type of training.

If this paints a gloomy picture of the effects of so rapid an expansion of the Child Guidance Services, it must be remembered that many of those without basic training will have learnt a great deal of value through their years of actual experience in the work. Yet it is necessary to be realistic over this aspect also—for such experience will be largely valueless except in a setting where learning by the whole Clinic team is possible. Even the value of good basic training can be seriously damaged if one's first placement is in a "bad" Clinic. Hence, in considering training, it is essential to think in terms of both the primary basic aspects and of the "in-service" teaching value of any functioning Child Guidance Clinic to its own team members.

It is an equally important need first to assess the role and function for which the worker is to be trained. The nature of this problem is illustrated in the described pattern of the training of Senior Registrars in Child Psychiatry in some training Clinics. Few would quarrel with the content of such training, if it is regarded mainly (or even solely) as a training in very intensive and highly specialised techniques of psychotherapy with children. Yet, in any Child Guidance Clinic which is providing a community service (as the majority of Clinics do, taking the country as a whole) will the task of the Psychiatrist lie solely (or even mainly) in such very intensive psychotherapy? The basic knowledge of psychodynamics which such training implies, and the ability to carry out such techniques, are essential for the child psychiatrist. But it is at least as important that he should learn to know when such techniques are neither necessary nor applicable; and to use methods of therapy which are much more "superficial" and "direct", but much more the methods of choice with a considerable proportion of his patients. In many of the therapeutic settings in which he will work, he will need to accept the impact of reality situations; and learn to use as constructively as possible reality situations which are far from "theoretically ideal".

Similar problems can arise with the basic training of some Psychiatric Social Workers. It is by no means unusual for newly qualified Psychiatric Social Workers in their first Child Guidance Clinic placement to show uncertainty (and sometimes even anxiety) over the discovery that an appreciable proportion of their work with parents is other than intensive case-work; and surprise that, in appropriate instances, less intensive techniques are equally

rewarding and valuable, yet demand as much technical skill from the worker as do wholely interpretive methods of case-work.

It is of course obvious that, with each of these disciplines, the skills in the use of "simpler" methods of therapy must be based on an adequate training in the more intensive techniques. But is there not a need to widen the training to include the use of all these various methods; and to provide skills in that most difficult differential assessment as to which is the method of choice in any given clinical situation?

For many members of all three of the basic disciplines of the Child Guidance team, another serious deficiency of basic training presents a very real problem. So much emphasis in our training is placed upon the abnormal, and upon the disturbance in the child or in his environment, that many of us learn little or nothing of normality. The trainee is often given only a limited concept of the wide range of norms for children of differing ages, or for differing social settings. If the worker has had no real experience of handling and observing "normal" children, how far can he hope to assess normality, and reassure the parent or school-teacher on that essential normality? Yet it is an appreciable part of the function of most Child Guidance Clinics, and of all preventive work in schools and Child Welfare Clinics, to do just this.

If the psychiatrist has no experience of normal childhood play, it is dangerously easy for him to misinterpret the child's activitiy in the diagnostic or treatment setting. How far can the Psychiatric Social Worker hope to discuss Johnnie's provocative behaviour with the parents if she has no certainty herself of the normal limits of attention-demanding activity in a 3-year-old? Unless the Educational Psychologist has seen the response of normal children in similar school situations, how far can he safely assess the anxiety reaction of the child to the test situation in the Child Guidance Clinic?

With the present dangerous trend towards dichotomy in child psychiatry as between its "medical" and "social" implication, it is not surprising that there has been much dispute as to the need for paediatric training for the child psychiatrist. It would be absurd to deny that experience of general children's medicine will be most valuable to any child psychiatrist in his task. But surely it is equally true that to emphasise paediatric training at the expense of experience in the social and dynamic aspect of psychiatry would indeed be putting the cart before the horse.

It is a basic tenet of Child Guidance work that the process is a team effort; and that the success of this work turns most of all on the successful integration of the team members with each other. Such a degree of integration requires that not only has each professional member his own specific role, but that each must accept a great deal of overlap and flexibility between these roles; it

implies a considerable mutual understanding and acceptance of the validity and purpose of each other's task. Such attitudes are not always easy to acquire in the basic training of each individual discipline, unless these trainings are more fully orientated towards, and integrated with, each other than is sometimes the case.

This same problem becomes of even greater significance if it is accepted that the Clinic itself must learn to function in a team relationship with the other Agencies concerned with the child. If this ideal is to be fully achieved, then training must be geared also to a greater understanding of the role of Probation Officer, the Health Visitor, the family doctor and the other workers concerned in the same basic task.

The co-ordination of theory and practice in training presents a difficult problem, but one which must be solved. It goes without saying that the practice of Child Guidance techniques for all three main disciplines can only be learnt in the Clinic; but it is doubtful if any Clinic can provide the facilities for full theoretical teaching from within its own resources. Yet, if the theoretical aspects of training are to become the responsibility of the appropriate University Departments (as would seem very reasonable), it is relevant to ask how many Universities have on their regular teaching staffs members of all three disciplines with recent adequate practical Child Guidance experience? Again, if theory and practice are to be split in time as well as place, can even the best teacher make theory really meaningful to students without practical experience in its application? Or can techniques of therapy in any of its many forms be taught before a theoretical background is understood? Must not these two progress in step with each other, and with the most careful co-ordination between University and Clinic placement? Much thought has gone into this problem in the field of social case-work training in recent years. Has there been a comparable advance in the training of the other two disciplines, and perhaps most of all, in the training of the psychologist?

At present, training tends to be restricted to a very small number of Child Guidance Clinics. Not all clinics can hope to have the facilities or staffs to make training possible, but it is likely that the numbers so employed could be substantially increased, if certain vital requirements were met. As anyone with training experience will know, the mere presence of a trainee in one's Clinic is a considerable stimulus, and a spur towards rethinking and validating (or otherwise) those many concepts and techniques which one has long taken for granted. But neither this stimulus, nor his own experience (necessary as both these are), will automatically convert even the good Child Guidance worker into a skilled teacher. There may be many valid analogies between therapy and the teaching of therapy or casework; but it is easy to carry these

similarities too far. There is need both for research into, and greater understanding of, the techniques of teaching in a Clinic setting. And this research and understanding need to consider not only the deeper emotional significance of the teacher/trainee relationship, but also those more superficial, but equally important practical aspects. How, for example, does one best teach basic interview techniques when the very presence of the trainee in the room raises new situations for both worker and patient? Here is a problem which has both deep and more "practical" aspects to be solved. Then, too, there will be the need to reduce the total Clinic case-load (or to enlarge its establishment) if any large scale teaching is to be done.

These factors may provoke considerable ethical problems for the Clinic worker who sees how much active treatment needs urgently to be done; and reality difficulties for the Hospital Board or Local Authority which is responsible for the provision of the Clinic's services to the community. But any attempt to provide adequate training "on the cheap" in terms of manpower or time becomes merely the excuse to use the trainee as an unpaid assistant who does all the odd jobs, and learns nothing in the process.

The shortages of Child Guidance personnel is still very severe. It is doubtful indeed if the present numbers of trainee Psychiatric Social Workers and Child Psychiatrists are even keeping pace with normal wastage. It has been said, probably with a good deal of truth, that this shortage stems rather from a failure to attract sufficient suitable trainees, than from the limitations of available training. But these two factors are closely inter-related, and we cannot hope to make these specialities attractive unless we provide a suitable, stimulating, and adequate training which will paint a clear picture of, and give a realistic lead into, the actual task which the Child Guidance Clinic has to perform.

This urgent need of active re-thinking of our ideas on training must be the excuse for this article which does not attempt any final solutions, but rather tries to pose some of the problems which must first be solved.

A Challenge to Social Work Education

By R. C. WRIGHT, B.A.

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Of all the groups of untrained social workers in the statutory services, the mental welfare officers have been the most persistent in their demand for training. The reasons why their cry went unheard by the Ministry of Health and the local authorities is now part of history—too recent to unravel but distant enough to be temporarily forgotten. It is necessary to remind you of the fact, only because already it is being said by some of those who know

little or did least to help, that "of course the mental welfare officers have resisted the idea of training" or that "psychiatric social workers have foiled any attempt at dilution". If anyone stands arraigned in my particular dock it is the local health authorities who have so often just not cared and are now quite surprised to find how angry and let down some mental welfare officers feel when they are being asked to start training or to train others in methods apparently unfamiliar to them twelve years after they were transferred from the Poor Law to mental health services.

The 1959 Mental Health Act along with the Younghusband Report is now stimulating the sluggish into activity. Yet, how ill-prepared we are for the implementation of the Working Party's recommendations! We are desperately short of university trained social workers who can teach theory and practice; our local authority doctors and administrators are only just discovering what psychiatrists and social workers are talking about; the untrained staff of our services are apprehensive lest someone is going to come along and tell them that their life's work has been a waste of time. The scramble to get on to the band wagon is already leading to the inevitable "short course of lectures", "a few visits of observation", "an extra-mural class in the sociology of education" etc. Who can blame the mental welfare officer for getting confused and angry and for trying to obtain whatever training or education he can in order to avoid being left high and dry by the ebb tide of promotion? If his comments on training are sometimes scathing, is it surprising when we see what he is sometimes offered as relevant teaching for his job?

The Younghusband report has focused our attention once again on the problem of training and provides us with a starting point for some experiments in the education of personnel for the social services. Its training recommendations have tremendous potentialities in them for good or ill. Very few people outside social work have really recognised that training carried out along the lines proposed in the Report means very much more than just putting on "a course of lectures at the local Tech." or "fixing up a bit of practical work". Perhaps more menacing than this underestimation of what is needed is the attitude of those whom one is beginning to meet more frequently up and down the country—the ambitious, conscientious half trained social worker who is busy swotting up the latest American literature (or who may have even visited Mecca itself) and is just waiting for the opportunity to spill out all he has read to the nearest client or student. (This surely must be happening too with psychiatric text books being increasingly read by general practitioners and medical officers of health). The fact that so many of these people at the bottom of their hearts think it all a lot of bunkum just makes the situation more tragic.

It is as well to remind ourselves at this point that if the Younghusband recommendations are implemented, the two year training of mental welfare officers is going to be basically the same as for other social workers of this type in the Health and Welfare services. Provision is made in the proposals for some specialisation especially in the mental health field. This is particularly likely to happen in the courses which are associated with large local authorities since we can expect these to have special mental health sub-departments. The influence of the psychiatric side of the service is likely, in any case, to be strong in the early years since it is obviously this aspect of local health services which is going to expand most rapidly in the immediate future.

The training of the mental welfare officer and similar social workers within courses outside the universities is going to pose a challenging educational problem. Since the students of these courses will, in the main, be recruited from an educational and intellectual group ineligible for university education (in this country at any rate) we will find ourselves faced with the question of how to teach ideas, hypotheses, and the uncertainties of human behaviour to groups of people who may find abstraction difficult and who will press for certainty and "facts". It will be only too easy for those who have brushed up against the current theories of psychiatry, psycho-analysis and social work to pass on what they have read or heard as if they were revealed truths. I am reminded of a wise comment by Paul Tappan *"the behaviour sciences may become merely a means of attaching prestige to highly personalised opinions concerning man in society".

These problems have arisen, of course, in other professional disciplines. There are always doctors, nurses, teachers etc. who treat the current theories and fashions in their subjects as if they were inviolable and undebatable. There is, however, something particularly repulsive in the possibility that we may produce a generation of social workers who, instead of being straightforwardly prejudiced, rude, or punitive, may quite unknowingly wrap all this up in undigested jargon and think that they are being modern and scientific.

Please don't misunderstand (and I know that some people would like to do so!)—I am not attacking the ideas, the theories or even the jargon as long as they are understood for what they are, a mixture of the proven, the unproven but likely, creative speculation and pure phantasy. It does seem, however, that we must clarify what are the most important elements we wish to teach and consider again whether the methods evolved mainly for university courses will be necessarily appropriate for other courses in which some of the students will be less intelligent. Perhaps we need

* Paul Tappan in *Social Problems*, Merrill, Rose, Dunham and Tappan. Published by Knopf, New York, 1950.

to hold on to one important fundamental of the university courses and that is their conception of the whole process of "training" the professional social worker as *education* not just training. If our first concern is to make the two year Younghusband courses a real *educational* experience for their students then we may avoid turning them into sources of purely technical "know-how".

This is no easy matter; we have not resolved this issue in our educational methods for school children. The temptation will be, as in the field of technology, to teach more and more, to fill up every possible moment of the day with alleged stimulation; to draw up erudite syllabuses which cover every aspect of half a dozen honours degree courses in the Social Sciences (shades of the new syllabus for mental nursing!).

Finally, then, if I was asked to suggest the basic elements around which all the other teaching of the social worker can be built up, these would be my suggestions:

(a) The existence of unreason and the ways it shows itself.
(b) The recognition of unreason in ourselves as well as in others.
(c) The historical or developmental approach to personality growth.
(d) The role of personal relationships in the developmental process and its subsequent importance in adult life.
(e) The recognition that "normality" can be thought of in a variety of ways—e.g. statistical, moral, relative, etc.
(f) The "correct" interpretation of the origins of situations and feelings may be less important therapeutically than the "appropriate" feeling response.

There is enough in these six simple topics to keep us all reading, arguing and researching for years; somehow we have to convey in these new social work courses the wish to do this along with the capacity sometimes to take actions, make decisions and offer help as if the arguments were not still taking place.

The General Nurse's Training and Psychiatry

By HELEN M. DOWNTON
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With the passing of the Mental Health Act 1959, the task of caring for the mentally ill and those in need of mental rehabilitation is now laid on a far wider section of the community. Since one of the basic aims of the new act is to bring mental health into line with physical health, entry to hospital for those in need of treatment is now on more informal lines. We know that plans are being made to expand community facilities in order to shorten or prevent their hospitalisation, and these two factors are obviously going to affect nurses working both in hospital and in the public health fields, many of whom at present have had little or no training in psychiatric nursing.

During the last ten or fifteen years much investigation and reviewing of nursing education has been taking place, and much has been done in the re-planning of programmes of nursing training and education, in order to try and meet the needs of the future, including the needs arising from the new outlook on mental health. It was obviously essential to try and begin to break down the extreme segregation of mental and general hospitals which existed up to the end of World War II, and to bridge the consequent gulf between the nursing of mentally and physically ill patients. The two were in completely water-tight compartments, and nurses from these two different fields appeared never to meet.

In order to bring together and open up the mental and general hospitals to each other, and in order to help nurses who were more interested primarily in the physical side of illness to realise the extreme importance and wide scope of the nursing of mental illnesses, plans for training have been made along the following lines so far: (1) The inauguration of experimental combined trainings in mental and general nursing, undertaken at two associated hospitals, so that on completion of just over 4 years' training the nurse can qualify for both the general and mental register; (2) the secondment of student nurses from a general to a mental hospital for a period of usually three months during the latter part of their basic training; this can be followed by a further fifteen months' post-registration training at the same mental hospital for qualification for the mental register; (3) the allocation of student nurses to psychiatric wards actually attached to the general hospital to give them some introduction to psychiatric nursing. In addition to the foregoing, visits and study days at mental hospitals have been arranged for sisters and staff nurses. The fact also cannot be overlooked that many nurses who have worked only in the general field have always had to cope with the psychological problems of their patients, unaided by any specific training for this, and some have gradually with experience, or with a natural aptitude, come to have a real and sympathetic understanding of this aspect of their patients' needs.

Now that the new Act is implemented, however, many nurses working in the general hospitals with no training or experience in psychiatric work, are viewing with a certain amount of apprehension and concern the prospect of admitting mentally ill patients to their wards, and being thrown into such work for which they obviously feel ill-prepared. How can this need be met over the next period—both for students and trained staff? Many of those responsible in general hospitals for nursing service and education have been trying to find ways and means of arranging some kind of preparation for those senior members of the nursing staff who will be involved in this new situation, for it is difficult indeed for ward sisters and tutors to teach and train student nurses to understand

and to care for these patients if they are unfamiliar themselves with this type of illness. Some nursing schools have been able to appoint tutors and ward sisters who are doubly trained but this has only been possible in a few instances. To cater for these new circumstances it would seem that a short period of study leave for Tutors and Ward Sisters for 10-12 weeks, with a carefully designed programme, might be a possible way of tackling the problem during the transition period. There would, of course, be a variety of opinions as to what the content of such a programme should be. It could, in such a short time, only be an introduction and orientation to the type of work, for instance, through the study of human relationships and the "technical, interpersonal and social aspects of the nurse's role in the team caring for the mentally ill patients". It might be hoped that some of those having the opportunity of even such a brief initiation as this would want to go on to take the complete mental training.

It seems increasingly clear too that all student nurses should in their basic training have an introduction to and some experience in psychiatric nursing if the community is going to think of mental and physical illness along the same lines. Since the revision of the General Nursing Council's syllabus for general training in 1954, lectures have been included in elementary psychology, human behaviour in illness, and mental disorders, for every student undergoing general training, but little opportunity has arisen to relate these to practical experience or teaching in the wards, and the value of these lectures has hence been largely lost. Consequently certain patients still continue to be thought of as "difficult" or "unco-operative" or "playing-up" with little understanding by those nursing them of the reasons or causes for these manifestations, and nurses also find it difficult to understand their own attitudes towards such patients. It is worth noting, however, that those who have had even a short introduction to psychiatric nursing in a mental hospital or a psychiatric ward acknowledge that they are much helped by this experience on return to the general hospital, in their approach to such patients, and also in recognising and dealing with their own reactions to them. If at this stage they can at least realise the importance of the good nurse/patient relationship as a "therapeutic tool", and their place in the team of those contributing towards the treatment or rehabilitation of these patients—it would seem that good foundations are being laid on which to build further psychiatric training.

It might be mentioned here that the New (1957) Syllabus and scheme of training for the certificate of mental nursing is an extremely interesting project in nursing education and training, and its emphasis on patient-centred teaching, and the integration of theory and practice all through the training will assuredly form the basis of all nursing training in the future.

The Probation Officer's Needs

By MARY KEEN

I.T.V.'s programme "Probation Officer", while undoubtedly providing the public for the first time with a sympathetic image of an understanding and helpful person, hardly presents the Probation Officer as a professional social worker with a body of knowledge and techniques which he brings to bear on the treatment of the delinquent. Yet, the Probation Service has been in the forefront of the post-war drive for the expansion and improvement of training in all the social services.

The introduction of the principle of generic training in social casework in the nineteen fifties has brought increasing recognition of the common basis which social workers in many different branches are using in their work with clients. Modern training has been aimed at defining and teaching these common elements and applying them through casework supervision to the particular settings in which the student is working—probation, family casework, almoning, child care, etc.

This development clearly owes a major debt to psychiatry and psychoanalysis in teaching us about mental growth and development and the origins of deviant behaviour. The debt has been so great, and the social worker's admiration and envy of the "magic" of psychiatry so immense that, until recently, it has been felt that only a psychiatrist could impart to us those truths without which we must flounder helplessly. As the profession of casework develops a personality of its own, it becomes apparent that it is not a poor second-best to psychiatry and psychotherapy, but a method in its own right, which can be taught by its own practitioners.

To the new probation officer, this recognition can be both alarming and reassuring. Faced as he is with a vast caseload of clients, many of whom display symptoms of text-book clarity, he is inclined to think that, if only there were enough psychiatrists to see them, all would be well. Meanwhile, he must muddle through as best he can. But experience will teach him that this was a mistaken belief and that many of his text-book cases will be returned to him by the psychiatrist as unsuitable for treatment, if ever they keep their appointment in the first place.

This brings me to my major criticism of casework training as applied to the work of the probation officer, and is linked with our continued dependence on formal psychiatry. By and large, the psychiatrist works most and best with the neurotic patient—one who has at least a dim awareness of something being not quite right with him, and of a need for help. Casework training based on work with neurotic clients tends to leave out of account the fact that the majority of the probation officer's clients are unwilling ones to whom everyone but themselves seems out of step. To

ask them "how do you feel about that?" is to be met with a sneer, and a brilliant interpretation may plummet into a deep silence which does not mean a struggle within the client about some aspect of transference but a mental tossing of coins between "The Blob" at the Ritz and "I was a Teenage Monster" at the Roxy.

The probation officer with the "new casework knowledge" is therefore placed in a considerable dilemma. In his advanced training, he has been taught to note the slightest shade of expression flitting across his client's face and to examine in detail all possible reasons for a five minutes' lateness for an appointment. Back in the Probation Office, he finds obscenities scrawled on the walls, ominous thumps—or even more ominous silences—in crowded waiting rooms, and a moon-faced lad in his office swearing he's going straight while furtively calculating if his P.O. has heard yet that he's up tomorrow on another charge. The probation officer might be tempted to throw up his hands in despair and seek refuge in a Child Guidance Clinic—and yet, in his quieter moments, he feels he is achieving something. His techniques are not entirely those he learned on his advanced casework courses, but then, neither are his clients.

It seems to me that for the probation officer, and other allied workers, training tends to give too little understanding and skill in handling the client who is immature rather than neurotic.

We need as effective an exploration of the field of character disorder as of neurosis, so that the theoretical basis for the mainly intuitive and sometimes startling techniques the probation officer employs may be mapped out and given the same respectability as the analyst's couch.

This means perhaps that the psychiatrist will need to come out of his consulting room and into the probation officer's setting so that he knows more about what the P.O. actually does. This leads me to my final point about the need for really effective psychiatric consultation. The Probation Service has affection and gratitude for a number of doctors who have given their services generously. They are too few however, and the demand for effective consultation becomes the greater as more and more students are trained on the basis of supervision, case conferences and teamwork. This type of training sets up considerable anxieties for the probation officer who, once back in his agency, is expected to function almost entirely on his own responsibility. I believe that were more psychiatrists to make themselves familiar with the work done by the probation officer, a system of teamwork and consultation could be built up which would help to bridge the gap for the newly-trained officer. At the same time, it would render more effective the established officer's work, as well as feeding back to the psychiatrist knowledge about a group of clients that he does not normally encounter in clinical work.

An Introduction to Psychiatry for Probation Officers

By E. W DUNKLEY, M.B., B.S., D.P.M.

This is an account of a brief course for trainee probation officers held at St. Pancras Hospital recently. The members of the course had already had some instruction in delinquency. The purpose of this course was to try to show the members something of the range of psychotic illness and how the results of such illness may bring someone into the care of the probation officer.

Only four morning sessions of 1½-2 hours were available. In this introductory talk an attempt was made to explain some of the points of approach of the psychiatrist to a patient, stressing that to the physician in charge of the patient the person is still a patient whether he be a prisoner or not. Mention was also made of the medical concept of professional secrecy and the necessity for consent for medical reports.

We considered Norwood East's dictum that the criminal is the man who commits a crime knowing that what he is doing is wrong but nevertheless takes a chance that he will get away with it. From here we passed on to consider the limitations of the help that the psychiatrist and the mental health services can give, realising that to ask for a psychiatric report can never solve the probation officers problem as if by waving a magic wand. Indeed it may raise further problems.

The members then went on to consider that even if a patient is found to be suffering from a mental illness which led to his misdemeanour it does not necessarily follow that the illness was curable. A special warning was sounded against "fussy psychiatry" where it was realised that at times nothing would be gained by sending or committing a patient to hospital simply because the presence of incurable mental illness had been diagnosed; and also provided that the crime with which the patient was charged was of a relatively minor nature and that his illness was not of sufficient severity to warrant his committal to hospital.

This point of view was discussed in relation to that group of people who repeatedly made suicidal gestures. The significance of the suicidal gesture as a cry for help on the part of the patient was noted.

On the first visit patients were demonstrated to show the range of psychiatric illness—these included patients suffering from dementing illness, from paranoid state and from manic illness. As each patient left the room the nature of the illness was briefly reviewed and also the ways in which it might lead the patient into antisocial conduct.

At the second visit we considered the complications of depressive illness—attempted suicide, homicide, committing some other crime to ensure imprisonment. A patient with marked guilt feelings was seen and this led to consideration of whether such a patient is in a fit state to be tried for an offence when such strong feelings of unworthiness might result in the case for the defence being inadequately put.

The third meeting was devoted to schizophrenia. At this meeting three patients were demonstrated, including one who it was alleged had made a homicidal attempt. Stress was laid on the concept of emotional dissociation and autistic thinking and their relationship to crime.

At the time of writing the fourth meeting has yet to be held; on that occasion it is hoped to consider psychopathy and to finish with a general discussion on the subject matter of the course.

The writer is indebted to Miss I. Forstner, Senior Psychiatric Social Worker to University College Hospital for her valuable collaboration in running the meetings.

The Training of General Practitioners in Psychiatry

By R. F. TREDGOLD, M.D., D.P.M.

The new Act, with its emphasis on treatment at home, will inevitably cast more responsibility on General Practitioners. They may have to sign recommendations to get patients compulsorily into hospital; they will probably be asked to give advice on the Act and its implications to many of their patients; and as the Act is designed to reduce prejudices and stigma, their answers on these questions will be extremely important. Besides this, it is probable that General Practitioners will see more cases of minor psychiatric disorders in their general practice, as the prejudice against them (and against certain types of treatment for them) disappears.

We must ask, therefore: what training has the General Practitioner had on this subject? There is no short answer here, for the variation is enormous. In medical schools before the war, training on the subject was little thought of: many of to-day's doctors were trained before the war. The ignorance that resulted left many feeling puzzled and inadequate, and so, irritated by "neurotics". The vicious circles set up by such situations are still spinning briskly.

It is true that since the war teaching has increased enormously; it has, moreover, been orientated to deal with the cases to be seen in general practice rather than those in mental hospitals. Most students these days get some systematic training, some acquaintance directly with psychiatric patients (though not always on

their own) and some supervision in handling them. There is, of course, no room for complacency here and much remains to be done. Some feel that the average student will fail to learn much until there are compulsory questions in psychiatry in the final examination of every University. This is no compliment to the keener student, but it would raise the standard of the lower level of knowledge, and so probably raise the standard of many General Practitioners. Even those schools with the fullest programme would scarcely regard it as adequate; and the time spent on psychiatry is still only a small fraction of that spent on medicine and surgery. Even conservative estimates put the proportion of psychiatric cases seen in general practice at a third of the total: others suggest it is far higher. Many of these are patients whom the doctor could treat effectively—if only he had more knowledge and more skill.

Clearly, the University teachers have the prime responsibility here; and no doubt they are moving forward. It is possible they could themselves be helped to provide even more, if some sort of "feed-back" from their pupils existed. How often, for example, do they hear comments or criticisms from an old student? Remarks on errors and omissions would be very welcome to any teacher who is interested in assessing his results—and who isn't? Old pupils are surely not too shy, but, of course, they may be too busy, to take the trouble to do this. In other countries, indeed, with a less conservative tradition in Universities, such criticism does come back more commonly—and more healthily.

What of post-graduate training? There are several examples of instruction open to General Practitioners, and to others faced with similar problems, such as industrial medical officers. There are, for instance, occasional set lectures and demonstrations at many schools; there are week-end courses organised by the National Association for Mental Health; and there are also group discussions run in the presence of psychiatrists, most notable of which has been Dr. Balint's (so well described in his book "The Doctor, his Patient and Illness"). Such groups appear to be on the increase, which indicates an encouraging demand from General Practitioners, but they can hardly yet cover more than the fringe of their requirements. In any case, doctors do not always find it so easy to learn completely new attitudes and techniques once they have become qualified. Such education must, therefore, be supplementary to under-graduate education, not a replacement of it. If so, the teaching schools clearly have some responsibilities here too, even if their prime concern is with undergraduates. The post-graduate schools and institutes must also play their part increasingly, and will no doubt respond more as more demands are made on them by General Practitioners. The trouble often seems to be that each side is waiting for the other to make the first move. Could General practitioners make their views better-known?

The Parental Role in the Care and Training of Mental Defectives

By W. WOLLEN, M.B.E., Med. Dipl., D.P.H., D.P.M.
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Now when the custodial attitude is making way rapidly for the dynamic approach to the problems of treatment and training of mental defectives, it is time for the parents to be uniformly recognised by the hospitals as members of the therapeutic team. In this paper, the attempt will be made to show how this so far neglected factor can be introduced into the training programme.

The plan to change the parental attitude does not aim at reducing the amount of work of the hospital staff, but at making the relative's life meaningful and worthwhile and free of guilt and frustration, and so reducing the shadow of the stigma resting on the patient. Parents have usually made considerable emotional investments, before the child was even born, and they naturally tend to look at him as an extension of themselves, so that a mentally defective child is viewed as a reflection of their own inadequacies and constitutes a serious threat to their ego.

But once they can feel sympathy with their child's needs and emotions, they will see him in a new and more hopeful light and will be able to show him the understanding, affection and acceptance so vitally necessary for his progress. To achieve this they should be given opportunities of meeting other parents and learn that they are not unique in their misfortune. During these meetings they can each make their own valuable contributions leading to better understanding of their children and to an acceptance of themselves as parents of mental defectives. As soon as they do so and can hope that the child's handicap will be reduced, their anxiety and guilt about "rejection" as well as their defensive or aggressive attitude towards the hospital will usually disappear or be considerably modified.

The admission of the patient into an institution does not automatically lessen the parents' need for help and support, because nearly all problems, complexes and doubts are liable to be reactivated immediately after separation; if they are not handled skilfully at this stage, they may remain as the basis of parental withdrawal or aggressiveness. It is obvious, therefore, that the training programme in hospital should preserve the parent-child relationship as much as possible.

The relationship of the mentally defective child or young adult with his parents is as important as that of a normal one, if not more so. Because of his limited abilities and dependence, a mentally handicapped child reflects to a much greater degree the personality and emotional attitudes of his parents so that every attempt at

altering the patient's patterns of behaviour should logically start with the parents. But we must also realise how much the child, by his handicap, has influenced the life of the family.

In U.S.A., a great deal of attention has been paid to the role of parents in training mental defectives, and much has been written on the subject of "counselling". In this country close contact with parents has been achieved in quite a few mental deficiency hospitals, either by frequent individual interviews or by forming parents' groups. The onus is always on the hospital to offer every facility to the parents for meeting each other as well as members of the staff. It may start with "open days", visits, participation in annual events, club meetings with shows, outings, social evenings, discussion groups, etc. Whatever it is called and how it is done seems to be immaterial provided that as many parents as possible participate. It is wise to remember, though, that those who do not join eagerly, usually need the help most.

Ideally, work with parents should start in their own homes as soon as mental defect is diagnosed, but as this paper deals with the situation in the hospital, it starts with the patient's admission. The old procedure of admission under the Mental Deficiency Acts, which was very like a criminal procedure, made the majority of parents feel ashamed and guilty and therefore in special need of re-assurance and support at this time. They should be seen by the head of the institution or at least by the senior member of the medical staff, without haste and in privacy. They should also be given every opportunity to see the hospital and should be encouraged to ask questions in order to air their emotions and dispel their doubts. The routine of hospital life, training, recreations and legal aspects, as well as their rights as parents should be explained to them. It must also be made perfectly clear that the hospital staff will maintain the link with home and become "agents" of the family, but will never try to replace the family as a vital centre in the patient's life. The doctor in charge of the patient will naturally play the most important role in establishing and maintaining close contact with the parents. He will arrange the initial interviews to obtain information and follow them by further discussions of diagnosis and progress. He must talk in a language which the particular parent concerned can understand and digest. He must face resistances towards his explanatory talks, because more often than not, he will be at the end of a long line of doctors whom parents have already consulted in increasing desperation.

In addition, interviews providing further information may be arranged with the chaplain, psychologist, therapists and social workers. Visits are also of crucial significance for the patient, parents and members of the staff, and their aim should be neither to spoil the patient nor to make martyrs of the parents or other members of the family. It is well to remember that each visit may

re-activate the patient's as well as the parents' problems and guidance in this respect is advisable.

Some parents may need special sessions, individually or, better, in groups. Both parents should normally be present and the aim of such sessions should be :

(a) To promote discussions on the patient's as well as the parental problems.
(b) To establish rapport with the parents.
(c) To help the parents to achieve emotional acceptance of the problem.
(d) To develop a positive outlook on the efforts of the hospital staff.

In such groups, parents will accept new ideas or even criticism from others in the same boat more readily than from the professional people who symbolise authority.

It must be stressed time and again that parents are the key people in the patients' lives and that the hospital staff cannot and will not be their substitute, as the close link with home is one of the most vital factors determining progress.

Because parents are members of the community it is clear that the acceptance by them and their neighbours of the patient's social and intellectual limitations is a major step forward in improving community mental health. Therefore the patient's chance of being able to lead a useful and happy life in the community will not only depend on the level of his behaviour but also upon the degree of their tolerance. This can best be achieved in the way described here.

The Mental Health Service in 1959

Both parts of the Ministry of Health's Report for 1959 are now available. Part I deals with administration of the National Health Service (as well as with Welfare, Food and Drugs and Civil Defence), and Part II is the Annual Report of the Chief Medical Officer "On the State of the Public Health". The following information is given for the benefit of readers who have not easy access to these two volumes (each costing 13s.); it is extracted from both of them although it is in the first part that detailed statistical statements and tables of the mental health service are chiefly to be found. Both Reports discuss the new Act at some length and Part I gives a useful summary of its chief provisions. But as it was not fully in force during the year under review, the old terminology is mostly used in presenting facts and figures.

Finance

During the years 1948-59, Regional Hospital Boards allocated to mental and mental deficiency hospitals 27.3% of their total capital expenditure. In the year 1958-59, the percentage so spent was 31.2. The proportion spent by each individual Board varied from 46% (South West Metropolitan) to 16.4% (Manchester).

An analysis of total hospital capital expenditure according to the type of hospital shows that in 1958-59, 26.8% was spent on psychiatric (mental and mental deficiency) hospitals and 55.8% on general hospitals: other types of hospitals come very much lower on the list, e.g. on those for chronic illness only 4.2% was spent.

The national average weekly cost of maintaining a patient in a mental hospital in 1959 was £6 19s. 2d. and in a mental deficiency hospital, £6 8s. 0d. Comparable figures given for other types of hospital administered by Regional Boards range from £23 16s. 11d. (acute) to £9 17s. 8d. (rehabilitation). The implications of these figures are discussed elsewhere in this issue (page 122).

Staff Situation

An increase in every type of personnel employed in the Mental Health Service is recorded, when compared with 10 years ago.

In 1949 there were 405 consultant psychiatrists: in 1959 the number had risen to 648, and in addition there were approximately 50 doctors starting their first year as senior registrars in psychiatry —some two thirds more than in general medicine or surgery and almost one fifth of all senior registrars.

Clinical psychologists in 1949 numbered 100, and in 1959, 148.

There were in 1949, 293 psychiatric social workers and "other social workers performing similar duties" as compared with 395 in 1959.

The total whole-time nursing staff in mental and mental deficiency hospitals in 1959 increased by 11% on the total for 1958. Whole-time *trained* staff increased by 1.5% (male) and 10.7% (female).

Mental Illness

Patients Under Care

As at 31st December 1959 the total number of patients under care was 136,138, the great majority of whom were in mental hospitals. This is a reduction of 5,490 on the previous year reflecting a continuation of the trends noted in the Ministry's 1958 Report. At the same time the number of patients admitted during the year—88% of them as "informal" or "voluntary"—increased from 91,558 to 95,344, an increase stated to be largely due to the fact that every year the length of stay in hospital becomes shorter. Thus of the 72,231 patients admitted during 1957 (the latest figures available), 29.3% had stayed one month, 51.4% 2 months, 62.5% 3 months, 75% 6 months, 79.1% 9 months, and 81.2% 12 months. The percentage left in hospital 12 months after admission was therefore approximately only 15%. It is not stated how many admissions were new and how many were re-admissions.

It must be remembered, however, that between 60% and 70% of mental hospital beds are still occupied by chronic patients, and

that most of them have been there for many years having been admitted before the days of modern methods of treatment. But it is encouraging to read that there are indications that their number is diminishing and that this "backlog of former years is most unlikely to be a reliable guide to future needs." Eventually it is suggested that less than 5% of all new psychiatric patients (excluding the aged) will need permanent supervision and only a fraction of them will need care in a mental hospital. The Chief Medical Officer of the Ministry, commenting on this situation in connection with long-stay patients, sounds a note of warning against undue optimism by noting trends that may have a reverse effect, viz.:

(1) Increased longevity is leading to a rise in the number of old people with unmodifiable cerebral deterioration needing hospital care. (In 1975, it is estimated that one person in 7 of the population will be over 65. The proportion with cerebral deterioration can only be guessed at.)
(2) There may be a decline in the rate of rehabilitation and discharge from long stay wards as the hard core of organically deteriorated patients is reached.
(3) There is no guarantee that the social atmosphere tolerating eccentrics and the economy enabling them to be largely self-supporting will continue indefinitely.

Meanwhile *overcrowding* in mental hospitals, though decreasing, still exists. In the area of the Newcastle Regional Hospital Board, for instance, it amounted on 31st December 1959 to 26.5% and in the Birmingham Region to 19.7%; in the North West Metropolitan Region and the Manchester Region on the other hand, it had fallen as low as 1.0% and 1.7% respectively. There were still 2,962 beds not in use because of lack of staff.

Day Hospitals at the end of 1959 numbered more than 40 with places for about 1,000 patients.

Out-Patients. First attendances at Out-Patient Clinics have, since 1949, increased by 54%, and first attendance at *Child Guidance Clinics* by 433% in this ten-year period. To quote from the Chief Medical Officer's Report: "It is clear that the wind of change has been blowing through psychiatry."

Mental Deficiency

On 31st December 1959 there was a total of 143,671 mentally subnormal patients under some form of care or supervision.

In hospitals under Regional Boards	58,118
In Rampton and Moss Side Hospitals	1,386
In other "deemed" accommodation	31
In Certified Institutions	1,471
In Approved Homes	851
Under Guardianship	1,451
Notified (single care)	585

In addition, there were 60,520 defectives living in the community under Statutory Supervision and 19,338 under Voluntary Supervision.

Whereas at the end of 1957 all the patients in mental deficiency hospitals were certified under the Mental Deficiency Acts, at the end of 1959 only 39% were certified and of the 4,831 admissions during the year 4,087 were "informal".

Discharges. Of the patients under order, 1,591 were discharged during the year: in addition, 9,662 patients were transferred to informal status but remained in hospital: 1,970 informal patients were discharged.

Overcrowding. This was slightly reduced in some Regions and strikingly so in East Anglia from 18% in 1958 to 7.3% in 1959. On the other hand, the Liverpool Region showed a rise from 3.2% to 11.9%. The highest rates were in the South West Metropolitan Region (28.0%), the Oxford Region (25.3%) and the Wessex Region (25.1%). The lowest were in the North West and South East Metropolitan Regions, there being none at all in the latter.

On 31st December 1959 there were 1,064 hospital beds not available, 759 of them by reason of lack of staff, despite the fact that 563 beds were added.

Waiting Lists for admission to hospital have increased so far as urgent cases are concerned—from 2,871 in 1958 to 3,056, and of this number 1,904 were children under the age of 16. Only the "non-urgent" list shows a slight decrease, from 2,882 to 2,862. In the Chief Medical Officer's Report this situation is discussed, and it is suggested that the possible causes are, first informal admission and an increased public confidence in hospitals and, secondly, the probability that there is an actual increase in the number of severely subnormal children due to live births of babies who would in the past have been still-born and to the survival of weaklings who would previously have died. An analysis made by the Manchester Regional Board shows that the number of applications in respect of "cot and chair" cases in 1959 showed an increase of 67 on those in 1954, whilst applications on behalf of high-grade adult patients decreased during the same period by 69. Hospitals all over the country, it is stated, report that their admissions are now mostly of the lower grade.

Little hope is given by the Ministry of any immediate relaxation of the seriousness of this problem other than the eventual development of community care facilities provided by local authorities, and the possibility of providing for some types of patients in units of general or children's hospitals.

Ascertainment. In 1959, a total tof 8,944 cases were reported to local health authorities; 4,428 of these were reported by local education authorities, being children found "ineducable" in school or requiring supervision on leaving school. Of the total number on whom action was taken, 739 were found hospital vacancies

(children, 286), 34 were placed under guardianship, 5 were sent to a place of safety, and the remainder placed under supervision.

Training Facilities

The total number of defectives receiving training as at 31st December 1959 was 19,596, which compares with 17,858 the previous year. They were distributed as follows:

	Under 16	*16 plus*
In Occupation Centres	11,171	8,425
In Industrial Centres	97	1,955
Home Training	605	1,438

Awaiting Training. This number increased from 9,310 to 10,073, of whom 2,603 were children under the age of 16. The waiting list for training in Industrial Centres was 5,675.

At the end of 1959 there were 239 whole-time and 83 part-time or less than part-time Centres provided by local health authorities with, in addition 12 Centres, including 6 full-time ones provided by voluntary bodies. During the year schemes for 44 new Centres were approved.

A valuable section of the Chief Medical Officer's Report is concerned with *rehabilitation* of mental and mentally subnormal patients. In it, useful information is given of outstanding experiments being made at various hospitals.

Another chapter with a bearing on mental health is the one on "Maternal and Child Care" which includes sections on the welfare of children in hospital, the need for "Guidance of parents of handicapped children" and on "Phenylketonuria".

Lastly we would call attention to the chapter on "Services Available to the Elderly", illustrating the extent of the need, and some of the experimental work being done by local authorities and hospitals to meet it. In his introduction to Part II of the Report, the Chief Medical Officer refers to the part to be played by preventive medicine in this connection in endeavouring to make ageing a gradual process of diminishing activity unimpaired by the grosser forms of incapacity either of mind or of body. What is wanted is that an ageing person "shall continue to be an asset to society, enriching it by his experience and possibly also by the active creative contribution of which he may still be capable."

Parliament, Press and Broadcasting

Parliament

In the Queen's speech on November 1st it was stated that the Government "will endeavour to improve the protection of the community against crime. The strength, efficiency and well-being of the police will be their continuing concern; and they will seek to make more effective the various methods of penal treatment. They will introduce a Bill to provide, in England and Wales, better

methods of dealing with young offenders; to extend compulsory after-care to prisoners and so discourage them from reverting to crime; and to improve the management of approved schools. Proposals for legislation in the same field in Scotland would be laid before Parliament.

The *Criminal Justice Bill* was laid before the House of Commons on November 17th. The Bill deals mainly with offenders under 21. Its main objects are to make wider provision for the use of borstal training and detention centres in dealing with young offenders; to discontinue short sentences of imprisonment as more detention centres become available; and to extend the provision of compulsory after-care. Changes are also proposed in the law relating to approved schools. Part I remodels the custodial forms of treatment for young offenders. No new forms of treatment are proposed, but existing methods, particularly borstal training and detention centres, are extended to more offenders. Imprisonment will eventually be restricted to cases where no other sentence is appropriate. The new scheme depends on the provision of more borstals and more detention centres, and will be introduced by stages as the additional institutions are ready.

Law on Suicide. Replying to a question by Mr. Kenneth Robinson on November 10th, the Home Secretary stated that he hoped to introduce legislation regarding the law on suicide and attempted suicide during the present session.

Training of Social Workers. On November 8th the Minister of Health, replying to a question, said that he could not promise during this session to introduce legislation to set up a National Council for Social Work training, as recommended by the Younghusband Report.

Returning to the attack on November 21st, Mr. Kenneth Robinson asked the Minister of Health *why* he was unable to introduce legislation in the present session, and what arrangements he proposed to make for training social workers in the health and welfare services pending legislation? Mr. Powell replied that he was in consultation with the Minister of Education about the early provision of courses on the lines recommended in the Younghusband Report. These, he said, need not await the establishment of a National Council. Mr. Robinson pointed out in a supplementary question that 18 months had already elapsed since the publication of the Younghusband Report and that, if legislation were not introduced this session, it would be another 18 months before the Council could be set up. He asked the Minister to "get a move on" in view of the fact that the Mental Health Act could not be implemented, so far as local authorities are concerned, until this Council is in being.

Rampton Special Hospital. In reply to a question by Mr. Norman Dodds, the Minister of Health cited reforms which had

taken place in Rampton during the past two years. These included an increased programme of social rehabilitation, including additional classes for patients; appointment of a psychiatric social worker and a chiropodist; modernisation of sanitary facilities; increased amenities for patients; and increased visits by people from outside to patients with no relatives. Other changes were also planned but some of these would depend on the recruitment of staff.

Television

On October 9th in the B.B.C. Programme "Meeting Point", the Dean of Trinity College, Cambridge, and a consultant psychotherapist were questioned by Ludovic Kennedy in a programme about "Guilt".

On November 1st Professor Bronowski began a new series, "Insight". The first programme, called "The Birth of Understanding", showed the birth of a child and tried to indicate how a newborn baby feels and how the baby learns later to explore his surroundings and build his vision of the world.

On November 18th A.T.V. featured a programme on Capital Punishment when under the chairmanship of Sir John Wolfenden, Lord Harding, Sir Linton Andrews, the Rev. Dr. L. Weatherhead, Mr. Gerald Gardiner, Q.C., and Dr. Edward Glover held an inconclusive discussion.

The work of the "Samaritans", dedicated to serve those who are tempted to suicide, was the subject of "Meeting Point" on November 20th. (A pamphlet on "Suicide—why not?", written by the Samaritans' Director, the Rev. Chad Varah, has been published by the S.P.C.K., price 1s.)

Sound Radio

A major feature has been the series of four programmes on Network Three from November 16th to December 7th on the theme "Crime and Punishment". The first two programmes examined the related ideas of "crime" and "punishment", and the third and fourth programmes discussed the treatment of the young offender and the adult criminal in this country at the present day. The B.B.C. issued a list of books for further reading in connection with this series, and weekend follow-up courses have been arranged by some adult education centres.

The "Parents and Children" series in Network Three has continued its series "About Learning", which has brought to the microphone a number of distinguished psychiatrists and psychologists. Reference has been made not only to experience in this country but to research work in other countries, notably that of A. R. Luria in the U.S.S.R. and Hebb in Canada. An account was given

in one programme by Mary Woodward of recent research work showing that poorly endowed children can learn much more than had been thought.

On November 27th in the Home Service, Dudley Perkins dealt with problems arising under the Mental Health Act, and paid special attention to the provisions to protect the patient and the community and to the establishment of Mental Health Review Tribunals.

Press

The autumn crop of conferences has included many with at least an indirect concern for mental health. There has been a fair harvest of press comment.

"Popular Culture and Personal Responsibility", a three-day conference sponsored by the National Union of Teachers, had as its most prominent theme concern for 'teen-age violence and delinquency and an examination of the general content of press, radio and television and their effects in shaping the "mores" of our time. The *Times Educational Supplement* on October 28th pointed out that the question was reduced in many people's minds to a choice between two alternatives: "Should people be allowed to read, view, or listen to, pretty well what they like, without interference from their betters; or should their betters be allowed to decide what is good for them?" "Both questions could respectably be answered in the affirmative," said the press report, and went on to examine the fallacies in many of the arguments advanced for and against.

Conferences of other organisations have continued to highlight public anxiety at the increase of crimes of violence, and much space has been devoted in some papers to reports slanted to support re-introduction of some form of corporal punishment and in other papers to campaigning against this tendency.

And with press concern about crimes of violence and sex offences there continues to be an oblique link with mental disorder. A recent article headlined "Frightened Mothers Want Pram Wardens" reports a move to establish a pram park where mothers can leave their babies while shopping to prevent the risks of their being kidnapped or hurt. The item concludes: "The mothers' fears are increased by the fact that the city has no fewer than five mental hospitals."

The Times on November 5th in a thoughtful essay from a religious correspondent discussed the relation between spiritual and mental health and the special role of the Church in World Mental Health Year. This theme appears increasingly in religious papers and parish magazines, and there have been many reports of Churches taking mental health and the needs of the mentally disordered as the focus for their services on Hospital Sunday.

On November 1st, the date on which the Mental Health Act came into force, the *Daily Telegraph* featured an article by John Prince on "From Custody to Cure in Mental Illness". It pointed out that though the Government has now, belatedly, accepted the Younghusband Report and announced its intention to establish a National Council for Social Work training, "unless it now acts with speed and vigour and unless local authorities can be induced to spend a reasonable proportion of their block grant on the mental health services, the schemes which on paper look promising could prove bitterly disappointing."

News and Notes

The Fountain Group

The Report of this Group for 1959 is the final one to be issued in its present form, for in the autumn of that year the Hospital Management Committee was dissolved upon the Group's being merged with Queen Mary's Hospital for Children at Carshalton. On November 30th the first contingent of 20 patients were transferred to Queen Mary's, followed at intervals thereafter by further transfers which early in 1961 would make a total of 320 children re-housed in 16 wards of their new home. Thirty patients over the age of 16 were also transferred to other hospitals in the Region, and more would follow. The vacated wards at the Fountain are not to be filled again, and the overall situation in regard to accommodation in the Region for severely sub-normal children is unchanged.

This Report strikes inevitably a nostalgic note, as all endings must, and it records a number of resignations of Senior Officers including the Assistant Psychiatrist (Dr. C. E. Williams), the Matron (Miss E. A. Bell), and her Deputy (Miss E. M. Richards). It also includes a farewell from the Physician Superintendent (Dr. L. T. Hilliard) on the eve of his retirement after 20 years' service to the hospital. In reviewing this period he notes the changes which have taken place in legislation and in attitudes and the part played by the Hospital in pioneering practical experiments in treatment and developing research. And the record is indeed one of which to be justly proud.

The Report of this last year's work exemplifies the Hospital's forward look. Dr. Kirman surveys the research activities carried on by his team, and there are contributions by the consultant neuropathologist, the senior biochemist, and the principal pyschologists. Dr. Tizard, Hon. Director of the three-year research project at Brooklands, Reigate, sponsored by the National Society for Mentally Handicapped Children, gives a brief account of the experiment which at the time of writing was about to come to an

end. "The gains are considerable," he says, "but it would be wrong to conclude that we can make the children fully normal. What we can do and are doing is to enable them to make fuller use of their potentialities—and these potentialities are greater than is usually thought." (It is expected that the film which was made about this project will be available from January, 1961. Enquiries should be sent to the National Society for Mentally Handicapped Children, Kingsway Chambers, 125 High Holborn, London, W.C.1.) The merging with Queen Mary's will not affect this particular research unit or other research projects in progress or planned, which will remain under the control of the Fountain.

Whilst inevitably there have been (to quote the words of Dr. Hilliard) "difficulties, distractions and sometimes disappointments" connected with the new developments, the fact that for the first time there will be provision for mentally handicapped children in a well-known childrens' hospital is surely an outstanding event in which the Fountain has played so large a part.

World Congress of Psychiatry

We are asked to announce that the Third World Congress of Psychiatry is being held June 4th to 10th, 1961, in Montreal at the invitation of McGill University and under the auspices of the Canadian Psychiatric Association. It is expected that some 3,000 delegates from psychiatry and allied fields (including sociology and social work) will attend.

Details may be obtained from the General Secretary, 3rd World Congress of Psychiatry, 1025 Pine Avenue West, Montreal 2, Canada.

"Poor Leviathan"

The new Minister of Health, Mr. Enoch Powell, devoted his first major speech—given on October 27th at a joint meeting of the English and Welsh Executive Councils Associations—to a thoughtful and refreshingly critical review of the present position of the National Health Service in its weakness and in its strengths. There were dangers implicit in a "monolithic State health service which he fully recognised—particularly in a time of rapidly changing attitudes and ideas, in coping with which "poor Leviathan is left lumbering behind, but there were advantages too and he was not satisfied that these were being reaped successfully. "If Leviathan tended to be rigid and centralised," he said, "at least he can combine great power and force with singleness of purpose."

He also extolled voluntary effort in the field, mentioning specially the Women's Voluntary Service, St. John Ambulance, the Red Cross, and the Friends of the Hospitals. "I am not," he declared, "going to cold-shoulder them or keep them out: I want to bring them further in. Their possibilities will not be realised unless the National Health Service and the local authorities are

both determined to treat them as genuine partners and collaborators"; and later he referred again to the great contribution which could be made by voluntary organisations in the field of community care.

Dealing with the subject of mental health, the Minister drew attention to the "dramatic possibilities inherent in modern trends," and paid a warm tribute to both voluntary and professional workers who have helped to produce the new climate of opinion. The need for recruiting and training social workers and others to make an expansion of local authority services for the mentally ill and the mentally sub-normal was one of which he was also fully aware.

He made it clear that this was a branch of the Health Service in which he was specially interested, and it is encouraging to note his declaration of faith made in the following words:

> *"I have already avowed that I come to the Ministry of Health with the intention of tilting the scales of my own personal interest and influence towards mental health, and it is here that the formulation of a clear long-term plan seems to me specially urgent and perhaps specially rewarding."*

May this be taken as a hopeful augury for the future?

A NOTE ON THE INGLEBY REPORT

After four years of study, the Committee on Children and Young Persons, set up by the Home Office under the Chairmanship of Viscount Ingleby, reported in October of this year. It was inevitable of course that any report on such matters as the treatment of juvenile offenders and the care of neglected and ill-treated children would arouse controversy, and some expressions of disappointment have come from those who had hoped for more drastic recommendations of changes in the law.

The Report does in fact recommend some very important changes in the law and most people will welcome the suggestion that the age of criminal responsibility should be raised now to 12 years, and later perhaps to 13 or 14. The proposal to retain the Juvenile Court system meets with less acceptance. The working party set up by the National Association for Mental Health and the Association of Psychiatric Social Workers to prepare evidence for the Committee concluded that while Juvenile Courts needed many improvements, the system was probably best suited to our setting and present culture and should therefore be kept. This view was not shared by all members of the N.A.M.H. Council, and their difference of opinion is reflected in the diverse reactions to this recommendation.

Differing opinions are also expressed about the recommendation to confine to local authorities and the police the powers of prosecuting neglectful and cruel parents which are now held also

by the N.S.P.C.C. The intention is that the National Society should concentrate instead on its preventive services and that prosecution should be initiated by as few authorities as possible.

Throughout the Report there is evidence of the Committee's purpose to deal constructively and humanely with children and parents who get into difficulties, while insisting at the same time that they take responsibility for their actions. No doubt this was the reason for the new term *"in need of protection or discipline"* recommended for use with children under 12, who commit offences, and for all children in need of care or protection. The present procedure whereby parents may charge their children as "beyond control" would be abolished and it would be left to the local authority to deal with such cases, and if necessary take the child to court as being "in need of protection or discipline".

While some find the new phrase severe in tone, few will quarrel with the proposal that parental responsibility should be recognised by requiring both parents to attend court when their child is charged with an offence. The same principle is behind the recommendation that juveniles charged with even a trivial offence should not be allowed to plead guilty without appearing, as is possible with certain offences in the adult courts. Stress on making court procedure simple and intelligible runs through many recommendations, from the proposed re-phrasing of the oath for children, to the section urging courts to be at pains to explain what they are doing and why, in order to win co-operation from both children and parents.

The Committee wish it to be made clear that mental suffering is included in the definition of cruelty and neglect, but while they believe that fines and imprisonment should be kept as possible penalties for offending parents, they emphasise the need for rehabilitation work in this connection.

Improvements in after-care services are urged, but no major innovations in dealing with offenders are proposed. The Committee decided that the Home Office should continue to be responsible for Approved Schools, and suggest extending the use of Attendance Centres to children from the age of 10 with an associated after-care service.

These recommendations are very important to all who are concerned with children's problems; an even more crucial proposal is to lay squarely upon local authorities the duty to prevent or forestall the suffering of children through neglect in their own homes, with power to provide material needs that cannot be met from other sources. This should gladden the hearts of all social workers. The extension and raising of standards in the preventive casework services has been asked for repeatedly by the N.A.M.H., and it is encouraging to find the Ingleby Committee giving much prominence to specific proposals on these lines.

Correspondence

Dear Dr. Tredgold,

I am very much averse to complaining about the content of articles in Journals and I would not do so unless there was considerable provocation. Unfortunately this exists in respect of your summary of Local Authority schemes under the title "Implementing the Mental Health Act" in the current issue of "Mental Health". It is quite clear that whoever did this has paid no attention at all to the objects of these schemes or the circular issued by the Ministry asking for their submission.

The schemes have two purposes. In the first place they represent the authority under which local health authorities will operate their services ("approved proposals" under S.20 of the 1946 Act), and for this reason they must be phrased widely enough to give the authority plenty of room to change its mind without having to come back to the Ministry for a formal amendment. Thus broad phrases of the "as may be necessary" type, which you criticise, were in fact inserted in many schemes at the Ministry's request to ensure that the authority had sufficiently wide powers. On the other hand authorities were asked to say in more detail what they intended to do—not what they would like to do, but what they hoped to do within the limits of practicality—within the next three years. It is justifiable to criticise what they intend to do as inadequate, but hardly realistic to complain, as you do, that they are not contemplating employing full-time psychiatrists, which they cannot get. Nor is it realistic to say that authorities "do not make it at all clear whether their 'after-care' will consist of individual or family casework or simply a routine enquiry". Would you expect any of them to give the latter alternative, and what precisely does it mean if they give the former?

Furthermore, you have obviously not noticed that many proposals contain stipulations regarding training in two places, both in the general section and in the section on Home Visiting. I wonder how many of the 20 authorities you say ignore this are the "better" authorities who might be relied upon to do it. It would be surprising if the Ministry neglected proposals regarding training with Younghusband in the offing, even if the local authorities did so.

You may be right that the local authorities' suggestions are "lukewarm, piecemeal and half-considered", but it is very difficult to base this on what is said in the proposals, and you are quite wrong in suggesting that they are seeking refuge in generalities and loop-hole phrases because they have "no special training" in the subject, and "financial support seemed somewhat doubtful." The generalities are deliberate and arise from the nature of the document, not from the intentions of the authorities.

I am particularly sorry that these badly conceived criticisms should appear in "Mental Health" at this time. No one pretends that local health authorities, except for the few progressives, are any more than at the beginning of a reorganisation and expansion of services, and there is much confusion and doubt as to what exactly is needed. This has been very much increased by the sudden transfiguration of social work into an accepted hierarchy of workers which everyone must have, though few health authorities really understand what it all means; and the prescribed training courses do not exist even if they did.

In these circumstances my own feeling is that helpful noises are better than critical ones. In the next few years we shall see what is actually done and then perhaps broadsides may be justified, or perhaps they will not!

Yours faithfully,

GORDON ROSE,

Senior Lecturer in Social Adminstration.

P.S. Perhaps you would care to publish the above.

We welcome Dr. Rose's letter and would certainly rather have criticism than "helpful noises". But we deplore the encouragement by the Ministry of the insertion of vague phrases into the Schemes, which seem to us to to make an already hazy situation even less clear.

On this point we have already quoted *The Times* comment (July 12th): *"Until we have the assurance of Mr. Walker-Smith that all the authorities know exactly what is expected of them, and are doing it, 'community care' will remain an unrealised ideal."*

We will try to answer Dr. Rose's minor points first:

"Authorities cannot get full-time psychiatrists." Is this really true? What is the evidence of occasions when they have tried (in vain) to do so? And if so, what are the reasons for failure? We must also challenge the comment that authorities were not influenced by their own lack of training or by their doubts of financial help. What training have they had? And are they free from doubts?

Dr. Rose's next sentence *seems* to mean that authorities cannot be expected to propose second-rate schemes and cannot be believed if they propose first-rate ones. Again (apparently) we are asked to assume that the "better" authorities are carrying out training schemes just because they have failed to mention them. If all this were true, it would make the proposals simply meaningless ritual. Even the pious hope that the Ministry would not neglect training schemes "with Younghusband in the offing" must be given up when one reads (see page 147) that the Minister could give no promise to introduce the necessary legislation this session.

We therefore remain impenitent and would support our criticisms by quoting from the recently published P.E.P. Report on "Community Mental Health Services" (obtainable from 16 Queen Anne's Gate, S.W.1, price 2s. 6d.) which readers wishing to pursue this whole subject further may care to read. In connection with staffing, the Report comments:

> *"There are certain fairly serious questions concerning staffing to which the returns submitted to the Minister of Health do not provide even an approximate answer. What exactly are the duties of staff engaged in the mental health services of local authorities? In what ways does the work undertaken by a psychiatric social worker differ from that of a mental welfare officer or a health visitor? . . . For this omission the local authorities cannot be held wholly responsible, for the Ministry's circular inviting proposals asked only for 'a general statement of subsequent intentions . . .'"*

Whilst noting that the proposals concerned with the mental subnormal are better defined in the Schemes than in the "far less familiar area of the community care of the mentally ill", P.E.P. nevertheless thinks that:

> *"It is not easy to convince oneself that such problems as the nature and extent of the needs of patients and their families, and the type of service and of staff best suited to meet these needs have always been adequately examined, or that the solutions put forward are necessarily the most effective."* (Page 352)

But what is more important than this is that these proposals surely have more than the two purposes Dr. Rose suggests. Their third purpose is that, in this time of re-organisation, expansion, confusion and doubt, they should allow of some informed discussion and criticism about their details, before too much time passes or money is spent. It is for this reason that we believe that criticism is justified and may possibly be welcomed by strong-minded people. If Dr. Rose feels that the authoritites are so insecure and immature that they cannot take criticism and merely need "helpful noises", we can only say we do not agree.—Editor.

Reviews

The English Prisons. By D. L. Howard. Methuen. 21s. 170 pp.

This is a book of quality and calibre compared to most books about prisons. The larger section of the book is historical. The material, which is full of interest even for the general reader, is well arranged to build up the reader's thoughts so that before he embarks on Part Two he will already have formed many ideas about the present and the future. The last of the historical chapters dealing with the twentieth century is positively exciting.

The author's major concern is for reform and rehabilitation. There is not much stress on man's rebellion against God and the reforming power of Jesus Christ is not brought out. Reform is nevertheless considered with great humanity and sympathy, never clinically. Convicts (ugly word) are individuals varying greatly, and quite like ourselves (awful thought). Mr. Howard has greater insights on reform than on punishment, not that they are opposed to each other. The reforming influence of punishment may be greater than we realise. Mr. Howard readily accepts the State's right to deprive a man of his liberty, though perhaps he sees it more as an opportunity for reform than as a punishment. He is less enthusiastic about milder forms of punishment such as corporal punishment. Yet to deprive a man of his freedom is not only a severe punishment, it can also be crippling and of itself defeat reforming influences. But Mr. Howard brings this out and so he shows us the attractions of Probation, Borstals, Open Prisons, the Hostel Scheme and the State's authority taking a parental slant towards prisoners.

ROY CALVOCORESSI

Memories of a Doctor in War and Peace. By Isabel Hutton, C.B.E., M.D. Heinemann. 25s.

The branch of medicine to which Lady Hutton owed her main allegiance was psychiatry and this story of her life includes memories of her first post as a young Edinburgh graduate on the staffs of Larbert and the Edinburgh Royal Mental Hospital. Later she worked under Sir Frederick Mott and Dr. Edward Mapother at the Maudsley Hospital, and for 14 years she was medical officer to the Ellen Terry Home for Blind Mentally Defective Children at Reigate. She was also closely connected with the British Hospital for Mental and Nervous Disorders in North West London.

It is interesting to be reminded from the record of her early professional career of how women medical students were at that time only barely tolerated and of the difficulties put in the way of women doctors—especially of married women doctors who wished to continue in work. We are also reminded of the immense change in public attitudes towards the propriety of sex education, for her

now well known book on "The Hygiene of Marriage" was felt by her advisers to be a risky venture and was studiously ignored by all the lay periodicals to which it was sent for review.

But it is not only with the life of a psychiatrist that this autobiography is concerned. In the First World War its author played a prominent part in the Scottish Women's Hospital teams in France and Serbia. In the Second World War she was with her husband (Lieut.-General Sir Thomas Hutton) in India where she won the friendship of many distinguished Indians and became Director of the Indian Red Cross Welfare Service.

Her life was packed full of rich and varied experiences into which she eagerly flung herself and which she describes with zest and charm and with an engaging objectivity.

It is sad that she died before her book was published but in its pages she will live on for those who knew her and they are grateful for so vivid a memorial. APHRA L. HARGROVE

Problems of Adolescent Girls. By James Hemming. Heineman. 18s. 179 pp.

Dr. Hemming studied 3,259 letters written by adolescent girls to a weekly periodical during 1953-1955 and used the vivid material to highlight their problems. Self-selected material, it is true, because they wrote voluntarily, but instead of revealing irresponsible rebels, the main impression is one of uncertainty and a longing to be accepted both socially and in the family. Many mothers and fathers must be surprised to find that 74% express a wish to share their problems with their parents.

This sympathetic book makes a convincing case for the need for parents to be helped to deal with the adolescent of today, and also for the duty of the secondary schools to provide "guidance" to young people during the emotional upheavals of adolescence.

ROBINA S. ADDIS

The Integrity of the Personality. By Anthony Storr. Heinemann. 15s. 174 pp.

"What exactly does go on during psychotherapy?" is a question asked by many students, and not a few therapists. Some of the latter, it is true, have written volumes in answer, but these are not always easy for the young student to follow. There is, therefore, room for a simple introduction to the subject, and Dr. Storr has provided this. Though a Jungian-trained analyst himself, he has not felt limited to the teachings of this or any other school, and has very rightly related his own training experience and views to the wider context of philosophy as well as of psychotherapy.

The book is well written, concise and clear, and is cordially recommended. R. F. TREDGOLD

RECENT PUBLICATIONS

We regret that owing to pressure on space this item has to be held over.

Our next issue will include reviews on the following books which we have received:

CLINICAL CHILD PSYCHIATRY. By Kenneth Soddy, M.D., D.P.M. Bailliere Tindall and Cox. 42s.

MENTAL HEALTH & SOCIAL POLICY, 1845-1959. By Kathleen Jones. Routledge & Kegan Paul. 28s.

FORGOTTEN MEN. A Study of a Common Lodging House. By Merfyn Turner. National Council of Social Service. 5s.

EXCEPTIONAL CHILDREN. By F. G. Lennhoff. Allen & Unwin. 21s.

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Winter 1961

NEWS MH LETTER

ISSUED BY THE NATIONAL ASSOCIATION FOR MENTAL HEALTH
39 QUEEN ANNE STREET · LONDON, W.1

N.A.M.H. Annual Conference, 1961

A preliminary notice of our next Annual Conference, to be held at Church House, Westminster, on March 9th and 10th, has been circulated to members. The theme this year is to be "Everybody's Business; Emerging Patterns for the Mental Health Services and the Public", and the Minister of Health, the Rt. Hon. Enoch Powell, will open the proceedings.

Detailed information will be available shortly.

Child Guidance Inter-Clinic Conference

The 17th Inter-Clinic Conference is to be held on Friday evening, April 14th and on Saturday, 15th. The subject for discussion will be "The Child Guidance Clinic and Delinquency", and papers will be based on a study of the Ingleby Report. The Conference will be open only to past and present members of child guidance teams and to child guidance students in training.

Hostels for Mentally Disordered Patients

Following a preliminary meeting in the summer to discuss After-Care Hostels for Psychiatric Patients, a Conference, attended by 200 delegates, was held on December 1st at the Cowdray Hall, London, for representatives of local authorities and hospitals and for interested individuals and members of voluntary organisations.

Under the chairmanship of Dr. T. P. Rees, papers were given by Dr. D. H. Clark (Medical Superintendent, Fulbourn Hospital, and Consultant Psychiatrist, Winston House, Cambridge), Dr. Lumsden Walker (Hortham Hospital, Bristol), Dr. K. A. Soutar (County Medical Officer of Health, Surrey), and Mr. J. E. Westmoreland (Mental Health Officer, Nottingham). In the afternoon there was a general discussion with comments from a Platform Panel, consisting of the Chairman and the speakers, together with Lady Adrian (Chairman of the East Anglian Regional Hospital Board's Mental Hospital Committee), Mr. W. C. King (Chairman, Mental After-Care Association), and Miss Mary Applebey.

The Conference was well reported in the press and the *Hospital and Social Service Journal* was particularly generous in giving it space in three consecutive issues—December 9th, 16th and 23rd.

"Challenge and Opportunity"

This Conference to deal with the subject of employment of the mentally disordered, held at Friends' House, London, on October 20th and 21st, was attended by 100 people representing hospitals, local authorities, disablement rehabilitation officers and employers. The numbers of each group had to be strictly limited and the demand from applicants from hospitals was in excess of places available: on the other hand, the 25 vacancies allocated for employers were not all filled.

The speakers included Dr. Wing (Maudsley Hospital) on his work with long-hospitalised schizophrenic patients, Dr. Clarke (The Manor, Epsom) on rehabilitation of the subnormal, Dr. Early and Mr. Turley on the Industrial Therapy Organisation established in Bristol, and Dr. Tennent (St. Andrew's Hospital, Northampton, and the Ex-Services Mental Welfare Society) on sheltered workshops. In addition, two personnel managers spoke of their employers' attitude to the employment of the mentally disordered and gave an encouraging account of their own experiences.

N.A.M.H. Courses

Part II of the course for Senior Officers in the Local Health and Welfare Services, tutored by Miss Howarth, was held in London from January 1st to 7th. A second course on similar lines will take place, also in London, for two weeks in April and one week in August. Miss Kate Lewis will be its tutor.

A residential course for masters and mistresses in preparatory schools is to be held at Halliday Hall, Clapham Common, from April 20th to 25th.

Applications are now being received for the 1961-62 Diploma Courses for Teachers of the Mentally Handicapped, including the course in Birmingham for Instructors of Mentally Subnormal Adults.

Scott Committee

On December 7th, the Scott Committee at present enquiring into the whole subject of staff training for work with the mentally subnormal, heard oral evidence—following on the written evidence previously submitted—from representatives of the N.A.M.H., namely Miss Applebey, Miss Dean, Dr. Gunzburg, Miss Rawlings and Mr. Saunders. A further hearing has been fixed for January 18th.

Residential Services

Parnham, Beaminster. In October, a very successful Exhibition and Open Day was held in the Home, and the main rooms made a lovely setting for some beautiful flower arrangements by members of the Dorset Floral Decoration Society. We are grateful to the local residents who take our old ladies out from time to time or invite them to their homes for tea, and the entertainments provided during the Christmas season were deeply appreciated. On December 15th, pupils from Broadwindsor School gave a delightful afternoon's display of dancing and sang carols. They were followed on subsequent days by recitals by the Beaminster Silver Band, the Netherbury Women's Institute and the Beaminster Congregational Church choir, ending with a party arranged by the Friends of Parnham.

A Management Committee for the Home is now in process of being set up, with Dr. W. J. T. Kimber (formerly Physician Superintendent of Hill End Hospital, St. Albans) as Chairman. A preliminary meeting has already been held.

Orchard Dene, Liverpool. A very generous gift from the Women's Licencee Trade Association has enabled the Management Committee to put in hand the conversion of the old central heating system to an oil-fired one. We have also received gifts from the Prescot Round Table and the Shrewsbury branch of the National Spastics Society which will be used to purchase permanent playground equipment. Other gifts include one from Pilkington Bros. Ltd., enabling us to replace the lower panes of glass in the play hut with glass that is "armour-plated".

At Christmas the gifts received included a decorated tree and toys from Mr. Hoyland, of the Blue Bell Inn, Huyton, with toys and sweets from the B.I.C.C. Ltd., Ravenhead Glass Works, the English Electric Co. (Liverpool) and Mrs. Hay, of Rainford, St. Helen's, all of which we gratefully acknowledge.

Fairlop Girls' Hostel, Leytonstone. The official opening of this hostel took place on October 19th and was a very happy event. Lady Norman welcomed Sir Arthur Howard, Chairman of the City Parochial Charities —whose generosity, it will be remembered, made this hostel project possible —as the chief speaker. We welcomed, too, Sir Donald Allen (Clerk to the Trustees) whose kindly informal visits to the girls at other times (including their Christmas party to which he brought Lady Allen) are always much appreciated. The Mayor and Mayoress of Leytonstone also attended.

At the time of writing all the 12 girls so far in residence are employed. On December 17th, by special invitation from the Fairlop boys, they took part in their party and had a wonderful time. Their own party was held on New Year's Eve when the boys' hospitality was returned and a coach-load of them arrived. On both occasions the standard of behaviour was excellent.

Fairhaven, Blackheath. Of the 21 boys in residence, 18 are in regular work. Some 12 old boys, looking very smart, came to the Christmas party. All of them told us about their jobs and it was good to hear how well they were managing. The majority came again to share Christmas fare with the boys who were spending their holiday in the hostel. A visit to Bertram Mills' Circus has been planned for the whole group early in the New Year.

The Chairman of the Hostels Committee, Mrs. E. Hailstone, J.P., has now completed her three years' term of office. We are greatly indebted to her for all she has done during this difficult pioneer stage when both hostels have inevitably suffered from many teething troubles. The Hon. Mrs. C. Vanneck has been elected by the Committee to succeed her in office.

Duncroft Approved School, Staines. Much consideration is being given at present to plans for the new buildings to be erected in the grounds of the School. Agreement has been reached with the Home Office for a school-room block with staff quarters, and for a hostel to accommodate 2 staff and 8 girls. Most of the latter will go out to work daily.

Staff News

At the end of August, *Miss Addis* went to Brussels to attend, by invitation, a World Health Organisation European Seminar on Child Guidance as a representative of the United Nations. Some 60 participants from 21 countries took part in the Seminar which lasted for twelve days.

It is with great regret that the N.A.M.H. records the resignation of *Miss Ross Hogg* to take up a social work post under the Thomas Coram Foundation (Foundling Hospital). She first joined our staff in the capacity of social worker in the wartime Regional After-Care office in Newcastle-on-Tyne when she was based on Durham. Subsequently she took over the post of Tutor to the Manchester Diploma Course.

The grief of her past and present students when they heard the news of her resignation is in itself a tribute to the value of her work with them. and she will be sorely missed also at 39 Queen Anne Street by those of us who were in contact with her there and especially by the Training and Education Department.

We wish her godspeed in her new post and despite our sorrow at losing her we are glad that her resignation involves a return to the profession dearest to her heart.

The Social Services Department has had to part with a valued member of its staff, *Mrs. Barnes,* who left in order to accompany her husband to Pakistan. The Residential Services Department is about to lose *Miss Brankin,* Matron of our Bognor Holiday Home. We greatly appreciate all she has done to give so many holiday parties a happy time, and we send her many good wishes for her retirement.

The Training and Education Department has welcomed *Miss Priscilla Whiffen,* as Tutor to the London In-Service Course.

New Year Honours List

It was with great pleasure that we found Dr. Isabel Wilson's name amongst those awarded a C.B.E. in the recent Honours List, "in recognition of her services as Medical Senior Commissioner, Board of Control."

National Society for Mentally Handicapped Children

It has now been agreed that the National Society and the N.A.M.H. would benefit by closer co-operation in connection with activities and projects for the welfare of the mentally subnormal. For this purpose, quarterly meetings between representatives of the two bodies have been arranged. Lord Feversham, Lady Adrian, Dr. D. D. H. Thomas and Miss Applebey are representing the Association, and the National Society is being represented by Lord Pakenham, Mr. D. H. Gray, Mrs. Drown and Mr. G. W. Lee.

Mental Health National Appeal

T.V. Appeal. The B.B.C. Television Appeal made on Sunday, September 18th, by John Freeman has realised to date £8,922 13s. 11d. and the money is still coming in almost daily, three months later. Contributions ranged from 6d. to £250 from old-age pensioners, children, former patients, groups and clubs and individuals. The work of counting, receipting and dispatching of thank-you letters was undertaken by a team of 10-14 voluntary workers co-operating with the Appeal office staff.

Mistletoe Ball. This pre-Christmas dance for teenagers at the Chelsea Town Hall on December 21st was such a success that requests have been made for another such Ball in 1961. 450 tickets were sold, and it is hoped that the Appeal may receive about £300. In the absence of Mrs. R. A. Butler, the Lady Mayoress of London, Lady Waley-Cohen, gave away prizes and danced two Scottish reels with great enthusiasm with her party. The Jamaican cabaret of limbo dancers was so popular that it gave a repeat performance after midnight.

London Flag Day. Final result of the 1960 London Flag Day was over £17,000. Mrs. Violet Hill, newly appointed organiser of the Flag Day for 1961, has started work in the Appeal Office, and the allotted date is Tuesday, October 10th. Mrs. R. A. Butler will again be the President and it is hoped to hold a party in early July for the borough organisers.

Carol Singing. This has proved an excellent fund-raiser during December, when 140 collection boxes with permits and leaflets were sent out to church, school and student groups, and to date £500 has been collected. Considerably more is expected.

Change of Address. The new address of the National (not "Joint") Appeal Office is now: 8 Wimpole Street, W.1; telephone number LAN 0145.

Northern Office News

An outstanding educational activity arranged by the Association's Northern Committee during the autumn was a meeting of general practitioners held at the Leeds General Infirmary, to discuss "The General Practitioner and the Mental Health Act—Responsibilities and Opportunities". Dr. J. M. Roberts (Consultant Psychiatrist, United Leeds Hospitals and Lecturer in the University Department of Psychiatry) and Dr. W. Edgar (Deputy Medical Officer of Health, Bradford) were the speakers and an excellent discussion was held.

A One-Day Conference on "Hostels in connection with the Mental Health Act" is to be held at the Civic Hall, Leeds, on February 21st (by kind permission of the Lord Mayor). A One-Day Conference will take place at the Friends' Meeting House, Manchester, on Alcoholism, on March 22nd, when the speakers will be Dr. Smith Moorhouse, and a member of A.A., with Dr. R. S. Ferguson (Consultant Psychiatrist, Blackpool and Fylde Area) as an additional member of the panel for discussion.

Further educational events include a course for Assistant Medical Officers in Maternity and Child Welfare and/or School Health Services in Newcastle-on-Tyne, from April 10th to 14th, arranged in conjunction with the Department of Psychological Medicine, King's College, Newcastle. The following week-end a Refresher Course for Assistant Medical Officers who attended the previous September Course will be held

The Exhibition of Flower Arrangements at Harewood House in October produced the sum of £575 (with possibly more to come) and was a delightful event which received wide press publicity. In the same month, £120 was raised by a member, Mrs. Horton-Fawkes, who held a musical evening at her home, Farnley Hall, near Leeds. A fashion show organised by Cresta Silks Ltd., Harrogate, resulted in a sum of £25 for the Committee's funds.

Northern Ireland's Mental Health Week

On September 26th, the Northern Ireland Association for Mental Health held a successful inaugural public meeting in Belfast which was attended by over 700 people. The proceedings were opened by the Association's President, Her Excellency The Lady Wakehurst, after which its chairman, Mr. Justice McVeigh, presided. Lord Cohen of Birkenhead spoke on "The Changing Outlook in the Mental Health Field", and Lady Norman, as Vice-Chairman of the N.A.M.H., gave an address on "New Opportunities for Voluntary Work" in this field.

The Association's meeting was followed by a well-attended three-day Conference on "Planning for Mental Health" sponsored by the Northern Ireland General Health Services Board, the Hospitals Authority, the Association of Health Committees, and the Association of Welfare Committees, with the support of the Ministry of Health and Local Government and the Queen's University of Belfast.